U.S. Department of Labor

Office of Administrative Law Judges
2 Executive Campus, Suite 450
Cherry Hill, NJ 08002

(856) 486-3800
(856) 486-3806 (FAX)

Issue Date: 03 August 2006

CASE NO.: 2005-BLA-05483

In the Matter of

M.G., **on behalf of**
J.G., deceased miner,
Claimant,

v.

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-interest.

Before:

JANICE K. BULLARD
Administrative Law Judge

DECISION AND ORDER ON THE RECORD

This proceeding arises from a claim for benefits under the Black Lung Act, 30 U.S.C. §§901-945 ("the Act") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.[1]

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a dust disease of the lungs resulting from coal dust inhalation.

[1] The Department of Labor ("DOL") has amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at C.F.R. Parts 718, 722, 725, and 726 (2002). They are applicable to all claims pending, on, or filed after that date. See 20 C.F.R. §718.101(b)(2001); 20 C.F.R. §725.2(c)(2001). Since Claimant's current claim was filed on June 4, 2001, the revised regulations apply to her claim. The United States Court of Appeals for the District of Columbia has upheld the validity of the revised regulations. See National Mining Assoc. v. Department of Labor, 292 F.3d 849 (D.C. Cir. 2002).

I. BACKGROUND

A. Procedural History

The deceased Miner ("the Miner") originally filed a claim for federal black lung benefits with the Department of Labor, District Director, Office of Workers' Compensation Programs ("OWCP" or "the Director"), in Pikeville, Kentucky on July 26, 1985. DX-(unmarked). On May 17, 2001, the Miner moved to have his claim voluntarily withdrawn. DX-(unmarked). By Proposed Decision and Order dated May 25, 2001, the Director found that withdrawal of the claim was in the best interest of the Miner and Ordered the claim withdrawn. DX-(unmarked).

The Miner filed another claim with the OWCP on June 4, 2001. DX-2. By Proposed Decision and Order dated April 23, 2003, the Director denied benefits. DX-26. The Director credited the Miner with thirteen (13) years of coal mine employment, and found that the evidence of record neither established that the Miner suffered from pneumoconiosis nor that he was totally disabled. Id. By correspondence filed May 1, 2003, the Miner requested a formal hearing before the Office of Administrative Law Judges ("OALJ") in order to contest the Director's denial. DX-27. On July 15, 2003, the Miner's claim was referred to OALJ. DX-33. By Order issued June 8, 2004, Administrative Law Judge ("ALJ") Joseph E. Kane remanded the case to the Director to provide the Miner with a complete OWCP pulmonary evaluation. DX-34 at 28-32. On October 26, 2004, it was determined by the OWCP that Dr. Glen Baker's clarification report of August 18, 2004, DX-34 at 2, brought the DOL examination into substantial compliance with the black lung regulations. DX-34 at 1.

On January 24, 2005, the Miner's claim was referred again to OALJ. DX-35. The case was subsequently assigned to me. By Notice issued January 30, 2006, I scheduled a formal hearing to be held on May 9, 2006 in Hazard, Kentucky. By correspondence dated February 23, 2006, counsel for the Miner informed the undersigned that the Miner had passed away and that the Miner's widow, M.G. ("Claimant"), wished to be substituted as the claimant in this matter. On April 27, 2006, Claimant moved for a decision on the record. By Order issued May 4, 2006, I granted Claimant's motion to amend the caption to include M.G. as a substitute party for the Miner. Furthermore, I also granted Claimant's motion for a decision on the record.[2] On July 20, 2006, the Director submitted his brief.[3] Claimant submitted her brief on July 3, 2006.[4] The following Decision and Order is based upon consideration of a thorough analysis of the evidence of record,[5] the arguments of the parties and the applicable law.

B. Issues

(1) Whether the Miner had pneumoconiosis pursuant to 20 C.F.R. §718.202;

---

[2] Contrary to my prehearing Order of January 3, 2006, Claimant prematurely submitted evidence, which was returned by correspondence dated February 14, 2006. By Order issued May 4, 2006, the parties were allowed time to submit evidence. No additional evidence was received.

[3] Denoted as "DB at -."

[4] Denoted as "CB at -."

[5] The evidentiary record in this case consists of Director's exhibits 1 through 37. They will be denoted as "DX-1" through "DX-37."

(2) Whether the Miner's pneumoconiosis arose out of coal mine employment pursuant to 20 C.F.R. §718.203;

(3) Whether the Miner was totally disabled pursuant to 20 C.F.R. §718.204(b); and

(4) Whether the Miner's pneumoconiosis substantially contributed to his total disability pursuant to 20 C.F.R. §718.204(c).

II. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement

Benefits are provided under the Black Lung Act for miners who are totally disabled due to pneumoconiosis. 20 C.F.R. §718.204(a). "Pneumoconiosis" is defined as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 20 C.F.R. §718.201(a). Because this claim was filed subsequent to January 19, 2001, Claimant's entitlement to benefits will be evaluated under the revised regulations set forth at 20 C.F.R. Part 718. In order to establish entitlement to benefits under Part 718, Claimant bears the burden of establishing the following elements by a preponderance of the evidence: (1) the Miner had pneumoconiosis, (2) the pneumoconiosis arose out of coal mine employment, (3) the Miner was totally disabled, and (4) the Miner's pneumoconiosis contributed to his total disability. 20 C.F.R. §725.202(d)(2)(i)-(iv); See Director, OWCP v. Greenwich Colliers, 512 U.S. 267 (1994); Perry v. Director, OWCP, 9 B.L.R. 1-1, 1-2 (BRB 1986).

1) Whether the Miner Had Pneumoconiosis

A finding of the existence of pneumoconiosis is determined pursuant to 20 C.F.R. §718.202. In addition, the regulations permit an ALJ to give appropriate consideration to "the results of any medically acceptable test or procedure reported by a physician and not addressed in this subpart, which tends to demonstrate the presence or absence of pneumoconiosis." 20 C.F.R. §718.107(a). Finally, the Benefits Review Board ("the Board") has held that all evidence relevant to the existence of pneumoconiosis must be considered and weighed. Mabe v. Bishop Coal Co., 9 B.L.R. 1-67 (1986) (the Board upheld a finding that the claimant had not established the existence of pneumoconiosis even where the X-ray evidence of record was positive).

20 C.F.R. §718.202(a) Evidence

There are four means of establishing the existence of pneumoconiosis set forth at §§718.202(a)(1) through (a)(4):

(1) X-ray evidence: §718.202(a)(1).

(2) Biopsy or autopsy evidence: §718.202(a)(2).

(3) Regulatory presumptions: §718.202(a)(3):

(a) §718.304 - Irrebutable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis.

(b) §718.305 - Where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven fifteen (15) years of coal mine employment and there is other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment.

(c) §718.306 - Rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978 and was employed in one or more coal mines prior to June 30, 1971.

and

(4) Physician's opinions based upon objective medical evidence: §718.202(a)(4).

The following is a discussion of the §718.202(a) evidence of record:

1. Chest X-Ray Evidence - §718.202(a)(1).

Under §718.202(a)(1), the existence of pneumoconiosis can be established by chest X-rays conducted and classified in accordance with §718.102.[6] An ALJ may utilize any reasonable method of weighing the X-ray evidence. Sexton v. Director, OWCP, 752 F.2d 213 (6th Cir. 1985). Generally, a physician's qualifications at the time he/she renders an interpretation should be considered. Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32 (1985). It is well established that it is proper to credit the interpretation of a dually qualified (B-Reader and BCR) physician over the interpretation of a physician who is solely a B-Reader. Zeigler Coal Co. v. Director, OWCP [Hawker], 326 F.3d 894 (7th Cir. 2003) (complicated pneumoconiosis); Cranor v. Peabody Coal Co., 22 B.L.R. 1-1 (1999) (en banc on recon.); Sheckler v. Clinchfield Coal Co., 7 B.L.R. 1-128, 131 (1984). The Board has also held that greater weight may be accorded the X-ray interpretation of a dually qualified physician over that of a physician who is only a BCR. Herald v. Director, OWCP, BRB No. 94-2354 BLA (Mar. 23, 1995) (unpublished). In addition, an ALJ is not required to accord greater weight to the most recent X-ray evidence of record, but rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to be considered. McMath v. Director, OWCP, 12 B.L.R. 1-6 (1988); Pruitt v. Director, OWCP, 7 B.L.R. 1-544 (1984); Gleza v. Ohio Mining Co., 2 B.L.R. 1-436 (1979).

The current record contains the following chest X-ray evidence:

[6] A B-reader ("B") is a physician who has demonstrated a proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the United States Public Health Service. 42 C.F.R. §37.51 A physician who is a Board-certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. §727.206(b)(2)(iii) (2001).

Date of X-Ray	Date Read	Exhibit No.	Physician	Radiological Credentials	Film Quality	Interpretation
(1)						
07/28/01	07/28/01	DX-11	Baker	B-Reader	2	0/1
07/28/01	08/25/01	DX-11	Sargent	B-Reader; BCR	1	Quality Reading
07/28/01	09/01/02	DX-13	Alexander	B-Reader; BCR	2	1/1
07/28/01	10/22/02	DX-14	Wheeler	B-Reader; BCR	2	No CWP
(2)						
10/11/01	10/11/01	DX-12	Dahhan	B-Reader	1	Negative

The X-ray of July 28, 2001 was administered by Dr. Glen Baker, M.D., and was read by four physicians. Dr. Baker, a B-Reader, interpreted the X-ray as Category 0/1. That is a negative reading for pneumoconiosis under the regulations. Dr. Michael S. Alexander, M.D., a dually-qualified physician, interpreted the X-ray as Category 1/1 positive. Dr. Paul S. Wheeler, M.D., also a dually-qualified physician, interpreted the X-ray as negative for pneumoconiosis. Although he acknowledged that the film was not completely negative, Dr. Wheeler noted "no silicosis or CWP" on his report. Finally, Dr. Nicholas Sargent, M.D., a dually-qualified physician, read the X-ray for quality purposes only. Since Dr. Alexander and Dr. Wheeler, two dually-qualified physicians, gave conflicting interpretations of the X-ray, I find that it is proper to defer to Dr. Wheeler's negative interpretation as it is corroborated by Dr. Baker's interpretation. Dr. Alexander's positive interpretation is the only positive one of record. As such, I find that the July 28, 2001 X-ray is negative for pneumoconiosis.

The second X-ray of record was administered by Dr. A. Dahhan on October 11, 2001. Dr. Dahhan, a B-Reader, was the only physician of record to read it and he interpreted it as negative for pneumoconiosis. Since his interpretation has not been rebutted, I find that the October 11, 2001 X-ray is negative for pneumoconiosis.

The record thus contains two X-rays which I have found to be negative for the presence of pneumoconiosis and none that are positive. It is within an ALJ's discretion to defer to the numerical superiority of X-ray evidence. Edmiston v. F&R Coal Co., 14 B.L.R. 1-65 (1990). Accordingly, I find that Claimant has not demonstrated the presence of pneumoconiosis by a preponderance of the X-ray evidence.

2. Biopsy or autopsy evidence - §718.202(a)(2).

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. 20 C.F.R. §718.202(a)(2). That method is unavailable here, because the current record contains no such evidence.

3. Regulatory presumptions - §718.202(a)(3).

A determination of the existence of pneumoconiosis may also be made by using the presumptions described in 20 C.F.R. §§718.304, 718.305, and 718.306. Section 718.304

requires X-ray, biopsy or equivalent evidence of complicated pneumoconiosis which is not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. 20 C.F.R. §718.305(e). Section 718.306 is only applicable in the case of a deceased miner who died before March 1, 1978. Since none of these presumptions is applicable, the existence of pneumoconiosis has not been established under 20 C.F.R. §718.202(a)(3).

4. Physicians' opinions - §718.202(a)(4).

The fourth way to establish the existence of pneumoconiosis under 20 C.F.R. §718.202(a) is set forth as follows in subparagraph (4):

> A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in §718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

Section 718.201(a) defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment" and "includes both medical, or 'clinical', pneumoconiosis and statutory, or 'legal', pneumoconiosis."

The record contains the following physicians' opinion evidence:

Dr. Glen Baker, M.D. (DX-8; DX-9; DX-11; DX-34 at 2)

Dr. Baker is Board-certified in Internal Medicine and Pulmonary Diseases and is a B-Reader. DX-11.

Treatment records prepared by Dr. Baker are found at DX-8 and DX-9. In the records found at DX-9, Dr. Baker checked-off a box labeled "CWP/COPD/CB/Pulm fibrosis." Dr. Baker circled CWP [coal workers' pneumoconiosis], COPD [chronic obstructive pulmonary disease], and CB [chronic bronchitis]. These records are dated November 1, 2001 through July 19, 2002. DX-8; DX-9.

Dr. Baker performed a full OWCP pulmonary evaluation of the Miner on July 28, 2001. DX-11. In that report, Dr. Baker documented that the Miner stated that he worked twenty (20) years underground as a coal miner. Under the cardiopulmonary diagnoses section of his report, Dr. Baker listed (1) COPD with moderate obstructive defect; PFTS; (2) mild hypoxemia; Po2; (3) chronic bronchitis: history of cough, sputum production and wheezing; and (4) ischemic heart disease: S/P AMI. Furthermore, Dr. Baker listed cigarette smoking/coal dust exposure as the etiology of the first three diagnoses. However, in the same report, Dr. Baker reported that the Miner did not have an occupational lung disease which was caused by his coal mine employment.

In response to ALJ Joseph E. Kane's Order of Remand issued June 8, 2004, Dr. Baker prepared a clarification report dated August 18, 2004, in order to clarify the opinions and observations he documented in his earlier report. DX-34 at 2. Dr. Baker reported that although he did not find evidence of clinical pneumoconiosis in his evaluation of the Miner, he did find that the Miner suffered from legal pneumoconiosis due to obstructive airway disease, chronic bronchitis, and resting arterial hypoxemia. Dr. Baker continued that those conditions may be caused by coal dust as well as by cigarette smoking.

Dr. Abdul Kader Dahhan, M.D. (DX-12)

Dr. Dahhan is Board-certified in Internal Medicine and Pulmonary Medicine and is a B-Reader. He prepared a report dated September 11, 2002. DX-12. Dr. Dahhan reviewed medical records as well and examined the Miner. The doctor concluded that there were "insufficient objective findings to justify the diagnosis of coal workers' pneumoconiosis." DX-12. He did, however, note a history of bronchitis.

"Other Medical Evidence" (20 C.F.R. §718.107(a))

Records of the Miner's treatment by Dr. Denis Sandin, M.D., at the Leatherwood-Blackey Clinic are in evidence at DX-10. The records reflect that the Miner was treated intermittently for COPD for the years 2000 through January, 2002.

Records of the Miner's treatment by Dr. Glen Baker for COPD are in evidence at DX-9 and DX-8. Dr. Baker treated the miner in 2001 and 2002.

Discussion

I have considered Dr. Baker's status as a treating physician, but find the record of his treatment of the Miner is insufficient to accord him additional weight because of his status. See, 20 C.F.R. §718.104. Dr. Baker's original opinion that the Miner's coal dust exposure contributed to his chronic bronchitis and COPD was not well-reasoned because the doctor relied upon an exaggerated coal mine employment history. Dr. Baker documented twenty years of coal mine employment, but the record establishes a history of thirteen years. Dr. Baker addressed the Miner's actual coal mine employment history when asked by the Director to clarify his initial report. In his supplemental report dated August 18, 2004, Dr. Baker wrote:

> [The Miner] does have legal pneumoconiosis, however, with obstructive airway disease, chronic bronchitis and resting arterial hypoxemia. These conditions may be caused by coal dust as well as by cigarette smoking. He does have a long history of cigarette smoking of approximately 30 years. If he indeed has only 13 years, this would be a *minimal contribution* to his condition, and I feel that the most likely cause of his COPD, resting arterial hypoxemia and chronic bronchitis, would be that of cigarette smoking, especially if he has only 13 years of coal mine employment. If he did have only 13 years of coal dust exposure and his dust exposure was not enough to cause X-ray changes, it probably *contributed*

minimally to his condition on moderate basis with FEV1 between 40 and 59% of predicted.

DX-34-2. In sum, Dr. Baker revised his original opinion and concluded that the Miner's pulmonary condition was due to his long history of cigarette smoking. The doctor did not completely disavow coal dust exposure as a causative agent to the Miner's condition, however, as he concluded his report by stating that the Miner has "a Class 3 impairment on basis of the AMA guidelines. This could be related in a small part to his coal dust, but the primary cause is his cigarette smoking." I acknowledge that the doctor initially diagnosed the Miner with chronic bronchitis, which falls within the definition of pneumoconiosis if it is related to the Miner's coal mine employment. Hughes v. Clinchfield Coal Co., 21 B.L.R. 1-134, 1-139 (1999). In addition, the regulations specifically state that the definition of "legal pneumoconiosis" includes "any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment." 20 C.F.R. §718.201(a)(2). I accord weight to the doctor's opinion.

Although Dr. Dahhan opined that there was insufficient evidence to diagnose coal workers' pneumoconiosis, he did note a history of bronchitis. Dr. Dahhan did not specify an etiology of the bronchitis. In addition, although the Director contested this element of entitlement, the Director did not address this issue in written closing argument.

In consideration of all of the evidence, I find that Claimant has established the presence of pneumoconiosis element of entitlement pursuant to 20 C.F.R. §718.202(a)(4).

2) Whether the Pneumoconiosis "Arose Out of" Coal Mine Employment

The Regulations mandate that in order for a claimant to succeed on a claim for benefits under the Act, "it must be determined that the miner's pneumoconiosis arose at least in part out of coal mine employment." 20 C.F.R. §718.203(a). There is a rebuttable presumption that the pneumoconiosis arose out of coal mine employment if a miner who is or was suffering from pneumoconiosis was employed for ten years or more in one or more coal mines. 20 C.F.R. §718.203(b); §718.302.

The Director credited the Miner with thirteen (13) years of coal mine employment. DX-26. I find that the record sustains such a finding, and the rebuttable presumption at 20 C.F.R. §718.203(b) is triggered. There is no evidence of record to rebut the presumption. Accordingly, I find that Claimant has established that the Miner's pneumoconiosis arose out of coal mine employment.

3) Whether the Miner was Totally Disabled

In addition to establishing the presence of coal workers' pneumoconiosis, in order for Claimant to prevail under the Act, she must establish that the Miner was totally disabled due to a respiratory or pulmonary condition. 20 C.F.R. §718.204(a). A miner is considered totally disabled within the Act if "the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner:

(i) From performing his or her usual coal mine work; and
(ii) From engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time."

20 C.F.R. §718.204(b)(1). The regulations at §718.204(b) provide the following five methods to establish total disability: (a) pulmonary function studies; (b) arterial blood gas studies; (c) evidence of cor pulmonale with right-sided congestive heart failure; (d) reasoned medical opinions; and (e) lay testimony. 20 C.F.R. §§718.204(b)(2) and (d). However, in a living miner's claim, a finding of total disability due to pneumoconiosis shall not be made solely on the miner's statements or testimony. 20 C.F.R. §718.204(d)(5); Tedesco v. Director, OWCP, 18 B.L.R. 1-103 (1994). Further, a presumption of total disability is not established by a showing of evidence qualifying under a subsection of §718.204(b)(2), but rather such evidence shall establish total disability in the absence of contrary evidence of greater weight. Gee v. W.G. Moore & Sons, 9 B.L.R. 1-4 (1986). All medical evidence relevant to the question of total disability must be weighed, like and unlike together, with Claimant bearing the burden of establishing total disability by a preponderance of the evidence. Rafferty v. Jones & Laughlin Steel Corp., 9 B.L.R. 1-231 (1987).

a) Pulmonary Function Studies

In order to demonstrate total respiratory disability on the basis of pulmonary function study evidence, a claimant may provide studies, which, after accounting for sex, age, and height, produce a qualifying value for the FEV1 test, and produce either a qualifying value for the FVC test or the MVV test, or produce a value of FEV1 divided by the FVC less than or equal to 55 percent. "Qualifying values" for the FEV1, FVC and the MVV tests are measured results less than or equal to values listed in the appropriate tables of Appendix B to 20 C.F.R. Part 718, 20 C.F.R. §718.204(b)(2)(i).

The record contains the following pulmonary function studies ("PFSs") summarized below:

Date	EX. No.	Physician	Age/ Ht.	FEV_1	FVC	MVV	FEV_1/FVC	Effort	Qualifies
07/28/01	DX-11	Baker	56 71.25	1.89	3.78	62	50%	Fair	YES FEV_1/FVC < 55%
10/11/01	DX-12	Dahhan	56 70.9"	2.27 2.44#	3.65 3.31#	n/a	62% 74%#	Good	NO FEV_1: 2.19
11/01/01	DX-8	Baker	56 71"	2.36*	3.92*	n/a	60%*	n/a	NO FEV_1: 2.19
02/22/02	DX-9	Baker	57 71"	2.42*	4.00*	n/a	61%*	n/a	NO FEV_1: 2.17

* Represents best value documented.
# Represents values obtained post-bronchodilator

The test administered by Dr. Baker on July 28, 2001 produced qualifying values. That PFS was subsequently validated by Dr. Nausherwan Khan Burki, M.D., on August 23, 2001. DX-11. Dr. Burki is Board-certified in Internal Medicine and Pulmonary Disease. Id. However, despite Dr. Burki's validation, I find that the PFS is not reliable because tests administered months later produced non-qualifying values, thereby compromising the validity of the earlier test. Since pulmonary function studies are effort dependent, disparately higher values tend to be more reliable than low values. Dr. Baker's subsequent tests are also of questionable probative value because effort and cooperation were not recorded. In addition, the number of tracings required by regulation are not of record. Even ignoring these defects, the tests produced values above those qualifying for disability under the Act. The test of October 11, 2001 is valid on its face and does not establish disability.

b) Arterial Blood Gas Studies

To establish total disability based on Arterial Blood Gas Studies, the test must produce the totals presented in the Appendix C to 20 C.F.R. Part 718, 20 C.F.R. §718.204(b)(2)(ii).

The record contains the following arterial blood gas study ("ABG") summarized below:

Date	EX. No.	Physician	pCO_2	pO_2	Qualifies[7]
07/28/01	DX-11	Baker	40	70	No
10/11/01	DX-12	Dahhan	38.5	86.4	No

Exercise during the test of October 11, 2001 was terminated because of fatigue. DX-12. Neither test of record produced results in the qualifying range.

c) Cor Pulmonale Diagnosis

A miner may demonstrate total disability with, in addition to pneumoconiosis, medical evidence of cor pulmonale with right-sided heart failure. 20 C.F.R. §718.204(b)(2)(iii). However, there is no evidence of cor pulmonale with right-sided congestive heart failure in this record.

d) Reasoned Medical Opinion

The fourth method for determining total disability is through the reasoned medical judgment of a physician that Claimant's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable and gainful employment. Such an opinion must be based on acceptable clinical and laboratory diagnostic techniques. 20 C.F.R. §718.204(b)(2)(iv). A reasoned opinion is one that contains underlying documentation adequate to support the physician's conclusions. Field v. Island Creek Coal Co., 10 BLR 1-19, 1-22 (BRB 1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. Id. An unreasoned or

[7] In order to qualify for total disability under arterial blood gas studies, Claimant's pCO_2 value would have to be equal to or lower than the given pO_2 levels found in the "Qualifies" column of this chart.

undocumented opinion may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 BLR 1-149, 1-155 (BRB 1989).

In his first report, dated July 28, 2001, Dr. Baker opined that the Miner did not have the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment. DX-11. This was based upon the OWCP pulmonary evaluation that he administered. Dr. Baker classified the Miner's pulmonary impairment as a moderate obstructive defect. Id.

In his report, dated September 11, 2002, Dr. Dahhan concluded that the Miner "has no evidence of pulmonary impairment and/or disability caused by, related to, contributed to or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis based on the clinical and physiological parameters of his respiratory system." DX-12. Dr. Dahhan did find, however, that the Miner suffered from a "variable obstructive ventilatory defect." Id.

Discussion

Both Dr. Baker and Dr. Dahhan diagnosed the Miner with an obstructive ventilatory defect. Dr. Baker opined that due to that defect, the Miner could not return to coal mine employment. Dr. Dahhan did not offer an opinion on the issue of whether or not the Miner could return to coal mine employment in consideration of his obstructive ventilatory impairment. Therefore, his opinion is not entitled to weight on this issue. Dr. Baker's opinion is undermined by his reliance upon a pulmonary function study that I have found to be of unreliable validity. However, the doctor's opinion is entitled to some weight because Dr. Baker had treated the Miner, and formed his opinion based upon his examination of the Miner, and the Miner's medical records. I find that the medical opinion evidence establishes that the Miner is totally disabled under the Act pursuant to 20 C.F.R. §718.204(b)(2)(iv).

4) Whether the Miner's Total Disability Was Due to Pneumoconiosis

The amended regulations at Part 725 mandate that a miner is eligible for benefits if his "pneumoconiosis contributes to [his] total disability." 20 C.F.R. §725.202(d)(2)(iv). "Total disability due to pneumoconiosis"[8] is defined at 20 C.F.R. §718.204(c) as follows:

> (1) A miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis…is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it:
>
> > (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or
> > (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

[8] I note that although there exists an ambiguity in the language of the analysis, 20 C.F.R. §725.202(d)(2)(iv) cross-references 20 C.F.R. §718.204(c).

20 C.F.R. §718.204(c)(1)(i) and (ii). The Sixth Circuit maintains that a Claimant must prove that the Miner's pneumoconiosis was a substantially contributing cause of his totally disabling respiratory or pulmonary impairment. See Tennessee Consolidated Coal Company v. Kirk, 264 F.3d 602, 611 (6th Cir. 2001).

In a living miner's claim, the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report. 20 C.F.R. §718.204(c)(2). A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data upon which the physician based the diagnosis. Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987). A "reasoned" opinion is one in which the ALJ finds the underlying documentation and data adequate to support the physician's conclusions. Fields, *supra*. A finding of total disability causation shall not be made solely on the miner's statements or testimony. 20 C.F.R. §718.204(d)(5). The Board has held that it is the Claimant's burden to establish total disability due to pneumoconiosis. Baumgartner v. Director, OWCP, 9 B.L.R. 1-65 (1986); Gee v. Moore & Sons, 9 B.L.R. 1-4 (1986) (en banc).

After his pulmonary evaluation of the Miner, Dr. Baker diagnosed legal pneumoconiosis and opined that the Miner was totally disabled. He attributed the Miner's ventilatory impairment to both cigarette smoking and coal dust exposure but failed to disclose the significance of the effect of each. Dr. Baker's first report was based upon a twenty (20) year history of coal mine employment which the Miner had related to him. He revised his opinion by supplemental report dated August 18, 2004. DX-34 at 2. Dr. Baker concluded that based upon coal mine employment of thirteen years, the Miner's coal dust exposure would be "a minimal contribution to his condition, and I feel that the most likely cause of his COPD, resting arterial hypoxemia and chronic bronchitis, would be that of cigarette smoking…" DX-34 at 2.

I accord significant weight to Dr. Baker's opinion because it is supported by the record. I note his qualifications and find that his opinion is entitled to enhanced weight because of his expertise in the field of pulmonary medicine. Dr. Baker failed to opine that the Miner's history of coal dust exposure materially effected or worsened his respiratory defect. Rather, Dr. Baker attributed the Miner's disability primarily to his long history of cigarette smoking. That opinion is corroborated by Dr. Dahhan. Claimant has failed to meet her burden in establishing that pneumoconiosis substantially contributed to the Miner's disability.[9] Accordingly, Claimant has not established entitlement.

III. CONCLUSION

Based upon my review of the relevant evidence of record, I find that Claimant has not established that pneumoconiosis was a substantial contributing cause to the Miner's total disability pursuant to 20 C.F.R. §718.204(c). Accordingly, her claim on behalf of the Miner for benefits under the Act must be denied.

[9] I have also reviewed the medical reports from Leatherwood-Blackey Clinic, found at DX-10, and find that they also fail to establish that the Miner's disability was due to his pneumoconiosis.

IV. ATTORNEY'S FEE

The award of an attorney's fee is permitted only in cases in which Claimant is found to be entitled to benefits under the Act. Since benefits are not awarded in this claim, the Act prohibits the charging of any fee to Claimant for representation services rendered in pursuit of the claim.

ORDER

The Claimant's claim on behalf of the deceased Miner for benefits under the Act is hereby DENIED.

A

Janice K. Bullard
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. §725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. §725.479(a).